

























































DENTAL CARE

CHILD'S NAME: _____ DOB: _____

DATE OF EXAMINATION: _____

GENERAL APPEARANCE OF TEETH AND MOUTH _____

M: (missing) X: (extraction indicated)
BLUE color represents restoration present
RED color represents restoration needed

	1 2 3 4 5 6 7 8		9 10 11 12 13 14 15 16	
UPPER	       	PERMANENT	       	BUCCAL LINGUAL
	A B C D E		F G H I J	
RIGHT	     	(MESIAL)	     	LEFT
	(DISTAL)		(DISTAL)	
	DECIDUOUS		TEETH	
	     		     	
	T S R Q P		O N M L K	
LOWER	       	TEETH	       	LINGUAL BUCCAL
	32 33 32 31 30 29 28 27		24 23 22 21 20 19 18 17	

DOES CHILD NEED FOLLOW-UP APPOINTMENT? YES _____ NO _____

WHY? _____

DATE OF CHILD'S NEXT APPOINTMENT: _____

DENTIST'S SIGNATURE _____

ADDRESS: _____

PHONE: _____